General Assembly **Amendment**

January Session, 2005 LCO No. **8056**

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Offered by:
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To: Subst. Senate Bill No. **1052** File No. 554 Cal. No. 651

(As Amended by Senate Amendment Schedules "A" and "B")

"AN ACT CONCERNING MEDICAL MALPRACTICE."

Strike section 11 in its entirety and substitute the following in lieu thereof:

"Sec. 11. Section 38a-676 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) With respect to rates pertaining to commercial risk insurance, and subject to the provisions of subsection (b) of this section with respect to workers' compensation and employers' liability insurance and professional liability insurance for physicians and surgeons, hospitals, advance practice registered nurses and physician assistants, on or before the effective date **[**thereof, every**]** of such rates, each admitted insurer shall submit to the Insurance Commissioner for the commissioner's information, except as to inland marine risks which by general custom of the business are not written according to manual

rates or rating plans, **[**every**]** each manual of classifications, rules and rates, and **[**every**]** each minimum, class rate, rating plan, rating schedule and rating system and any modification of the foregoing which it uses. Such submission by a licensed rating organization of which an insurer is a member or subscriber shall be sufficient compliance with this section for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the manuals, minimums, class rates, rating plans, rating schedules, rating systems, policy or bond forms of such organization. The information shall be open to public inspection after its submission.

(b) (1) Each filing **[**as**]** described in subsection (a) of this section for workers' compensation or employers' liability insurance shall be on file with the Insurance Commissioner for a waiting period of thirty days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed thirty days if the commissioner gives written notice within such waiting period to the insurer or rating organization which made the filing that the commissioner needs such additional time for the consideration of such filing. Upon written application by such insurer or rating organization, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of sections 38a-663 to 38a-696, inclusive, unless disapproved by the commissioner within the waiting period or any extension thereof. If, within the waiting period or any extension thereof, the commissioner finds that a filing does not meet the requirements of said sections, the commissioner shall send to the insurer or rating organization which made such filing written notice of disapproval of such filing, specifying therein in what respects the commissioner finds such filing fails to meet the requirements of said sections and stating that such filing shall not become effective. Such finding of the commissioner shall be subject to review as provided in section 38a-19.

(2) (A) Except as provided in subparagraph (C) of this subdivision, each filing described in subsection (a) of this section for professional liability insurance for physicians and surgeons, hospitals, advanced practice registered nurses or physician assistants shall be subject to prior rate approval in accordance with this subsection. On and after the effective date of this section, each insurer or rating organization seeking to increase its rates over the rates in the insurer's previous filing for such insurance by seven and one-half per cent or more shall (i) file a request for such change with the Insurance Commissioner, and (ii) send written notice of any request for an increase in rates to insureds who would be subject to the increase on such form as the commissioner prescribes by certified mail, return receipt requested. Such request shall be filed and such notice shall be sent at least sixty days prior to the proposed effective date of the increase. The notice to insureds of a request for an increase in rates shall indicate that the insured may request a public hearing by submitting a written request to the Insurance Commissioner not later than fifteen days after the date notice was sent. Any request for an increase in rates under this subdivision shall be filed after notice is sent to insureds and shall indicate the date such notice was sent. Not later than fifteen days after such notice is sent, the insurer shall submit a list to the commissioner indicating the name of each insured to whom notice was sent and whether a return receipt was received for the notice sent to the insured.

(B) The Insurance Commissioner shall review each filing under subparagraph (A) of this subdivision and shall (i) not approve, modify or deny the request until the expiration of the period for insureds to request a hearing pursuant to subparagraph (A) of this subdivision, and (ii) hold a public hearing, if requested by insureds, on such increase prior to approving, modifying or denying the request. The Insurance Commissioner shall approve, modify or deny the filing not later than forty-five days after its receipt. Such finding of the commissioner shall be subject to review as provided in section 38a-19.

(C) (i) Any review or hearing under this subdivision shall be

conducted within available appropriations. If appropriations are not available for such review and hearing, the filing shall be subject to subsection (a) of this section.

(ii) In any fiscal year, not later than five business days after the commissioner determines that appropriations are not available for such review and hearing, the commissioner shall publish notice in the Connecticut Law Journal and on the Insurance Department's Internet web site. The notice shall indicate that appropriations are not available in the current fiscal year for review and hearing under this subdivision and that such filings for the remainder of the fiscal year shall be made in accordance with subsection (a) of this section.

(c) The form of any insurance policy or contract the rates for which are subject to the provisions of sections 38a-663 to 38a-696, inclusive, other than fidelity, surety or guaranty bonds, and the form of any endorsement modifying such insurance policy or contract, shall be filed with the Insurance Commissioner prior to its issuance. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing a procedure for review of such policy or contract. If at any time the commissioner finds that any such policy, contract or endorsement is not in accordance with such provisions or any other provision of law, the commissioner shall issue an order disapproving the issuance of such form and stating the reasons for disapproval. The provisions of section 38a-19 shall apply to any such order issued by the commissioner."

Strike section 14 in its entirety and substitute the following in lieu thereof:

"Sec. 14. Section 38a-395 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2006*):

[The Insurance Commissioner may require all insurance companies writing medical malpractice insurance in this state to submit, in such manner and at such times as he specifies, such information as he deems necessary to establish a data base on medical malpractice,

including information on all incidents of medical malpractice, all settlements, all awards, other information relative to procedures and specialties involved and any other information relating to risk management.**]**

(a) As used in this section:

(1) "Claim" means a request for indemnification filed by a physician, surgeon, hospital, advanced practice registered nurse or physician assistant pursuant to a professional liability policy for a loss for which a reserve amount has been established by an insurer;

(2) "Closed claim" means a claim that has been settled, or otherwise disposed of, where the insurer has made all indemnity and expense payments on the claim; and

(3) "Insurer" means an insurer that insures a physician, surgeon, hospital, advanced practice registered nurse or physician assistant against professional liability. "Insurer" includes, but is not limited to, a captive insurer or a self-insured person.

(b) On and after January 1, 2006, each insurer shall provide to the Insurance Commissioner a closed claim report, on such form as the commissioner prescribes, in accordance with this section. The insurer shall submit the report not later than ten days after the last day of the calendar quarter in which a claim is closed. The report shall only include information about claims settled under the laws of this state.

(c) The closed claim report shall include:

(1) Details about the insured and insurer, including: (A) The name of the insurer; (B) the professional liability insurance policy limits and whether the policy was an occurrence policy or was issued on a claims-made basis; (C) the name, address, health care provider professional license number and specialty coverage of the insured; and (D) the insured's policy number and a unique claim number.

(2) Details about the injury or loss, including: (A) The date of the

injury or loss that was the basis of the claim; (B) the date the injury or loss was reported to the insurer; (C) the name of the institution or location at which the injury or loss occurred; (D) the type of injury or loss, including a severity of injury rating that corresponds with the severity of injury scale that the Insurance Commissioner shall establish based on the severity of injury scale developed by the National Association of Insurance Commissioners; and (E) the name, age and gender of any injured person covered by the claim. Any individually identifiable health information, as defined in 45 CFR 160.103, as from time to time amended, submitted pursuant to this subdivision shall be confidential. The reporting of the information is required by law. If necessary to comply with federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996, (P.L. 104-191) (HIPAA), as from time to time amended, the insured shall arrange with the insurer to release the required information.

(3) Details about the claims process, including: (A) Whether a lawsuit was filed and, if so, in which court; (B) the outcome of such lawsuit; (C) the number of other defendants, if any; (D) the stage in the process when the claim was closed; (E) the dates of the trial, if any; (F) the date of the judgment or settlement, if any; (G) whether an appeal was filed and, if so, the date filed; (H) the resolution of any appeal and the date such appeal was decided; (I) the date the claim was closed; (J) the initial indemnity and expense reserve for the claim; and (K) the final indemnity and expense reserve for the claim.

(4) Details about the amount paid on the claim, including: (A) The total amount of the initial judgment rendered by a jury or awarded by the court; (B) the total amount of the settlement if there was no judgment rendered or awarded; (C) the total amount of the settlement if the claim was settled after judgment was rendered or awarded; (D) the amount of economic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (E) the amount of noneconomic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (F) the amount of any interest awarded due to the failure to accept an offer of

judgment or compromise; (G) the amount of any remittitur or additur; (H) the amount of final judgment after remittitur or additur; (I) the amount paid by the insurer; (J) the amount paid by the defendant due to a deductible or a judgment or settlement in excess of policy limits; (K) the amount paid by other insurers; (L) the amount paid by other defendants; (M) whether a structured settlement was used; (N) the expense assigned to and recorded with the claim, including, but not limited to, defense and investigation costs, but not including the actual claim payment; and (O) any other information the commissioner determines to be necessary to regulate the professional liability insurance industry with respect to physicians, surgeons, hospitals, advanced practice registered nurses or physician assistants, ensure the industry's solvency and ensure that such liability insurance is available and affordable.

(d) (1) The commissioner shall, within available appropriations, establish an electronic database composed of closed claim reports filed pursuant to this section.

(2) The commissioner shall, within available appropriations, compile the data included in individual closed claim reports into an aggregated summary format and shall prepare a written annual report of the summary data. The report shall provide an analysis of closed claim information including a minimum of five years of comparative data, when available, trends in frequency and severity of claims, itemization of damages, timeliness of the claims process, and any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

(3) The annual report shall include a summary of rate filings for professional liability insurance for physicians, surgeons, hospitals, advanced practice registered nurses and physician assistants, which have been approved by the department for the prior calendar year, including an analysis of the trend of direct losses, incurred losses, earned premiums and investment income as compared to prior years. The report shall include base premiums charged by insurers for each

specialty and the number of providers insured by specialty for each insurer.

(4) Not later than March 15, 2007, and annually thereafter, the commissioner shall submit the annual report to the joint standing committee of the General Assembly having cognizance of matters relating to insurance in accordance with section 11-4a. The commissioner shall also (A) make the report available to the public, (B) post the report on its Internet site, and (C) provide public access to the contents of the electronic database after the commissioner establishes that the names and other individually identifiable information about the claimant and practitioner have been removed.

(e) The Insurance Commissioner shall, within available appropriations, provide the Commissioner of Public Health with electronic access to all information received pursuant to this section. The Commissioner of Public Health shall maintain the confidentiality of such information in the same manner and to the same extent as required for the Insurance Commissioner."